Executive Committee
Summary of Meeting Minutes
March 20, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler –	Kevin Kirkpatrick - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski -
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch –	Alisha Timmerman -
Julie Fugenschuh –	
Jodi Tomlonovic –	

Introduction
David called the roll call. Executive Committee attendance is as reflected above and quorum was not met.

Approval of the Executive Committee Meeting Minutes of February 27, 2018
Minutes of the Executive Committee meeting of February 27, 2018 were not approved because quorum was not met. David asked that an electronic vote be initiated for Executive Committee members to approve the minutes of the January 4 and February 27 Executive Committee meetings.

Recommendations Discussion
Q2 SFY18 Recommendations Subcommittee Update
David referred to the draft of the Q2 SFY18 recommendations document and gave an update from the March 8, 2018 subcommittee meeting. He stated that the aim is to get the recommendations to Director Foxhoven by the April 11, 2018 Executive Committee meeting and to share them at the next Full Council meeting on May 3, 2018. Lindsay explained that the current recommendations are for Q2 SFY18 IA Health Link public comment meetings and, as the meetings have concluded, no further recommendations for the meetings are required per legislation. The MAAC may continue to make general recommendations at any time. David invited feedback from the Committee on the draft recommendations. Dan Royer suggested more clarification on data regarding claims that are suspended versus denied and Cindy suggested that dollar amounts for items such as inpatient and outpatient claims paid be provided by the Department. David referenced the March 9, 2018, email from Dan Royer that had been distributed to Executive Committee members regarding how Medicaid and MCO operations are impacting hospitals and health systems. He stated that he would like to include some of the relevant recommendations from his document in the Q2 SFY18 recommendations. David suggested discussing Dan's ideas at the March 30, 2018, recommendations subcommittee meeting.

Long Term Services and Supports Presentation (LTSS)

Deb Johnson reviewed the Home- and Community-Based (HCBS) Waiver application process. Applicants can be self-referred, referred by schools, referred by local DHS offices, MCOs, and many other avenues. Income Maintenance Workers (IMWs) assist with the Waiver application and the applicant has to choose between institutional or community services. If determined financially eligible for Medicaid and HCBS services, the IMW requests a waiver slot. If a waiver slot is not available, the applicant will be put on a waiting list and a Notice of Decision will be sent to the applicant. If a waiver slot is available, the next step is completion of a Level of Care (LOC) assessment. An LOC determination is then made upon review of the individual's needs as identified in the assessment. An LOC is not an approval of services but rather a determination of HCBS eligibility. The approval process for HCBS applicants can take several months to complete, depending upon how quickly the assessment can be scheduled and completed, and whether all necessary information is submitted timely for the LOC decision. If approved for LOC and HCBS services, it is determined whether the member is eligible to enroll with an MCO to receive services or receive services under the Fee-for-Service (FFS) program. Once the applicant has been determined eligible for HCBS and Medicaid coverage, either a case manager from the member's selected MCO, or a FFS case manager will develop a service plan with the member and the member's Interdisciplinary Team (IDT). The service plan can change in accordance with the member's needs and the LOC, Medicaid eligibility, and service plan is re-evaluated annually. Deb clarified that service plans are authorized by the state or the MCO; not the case manager. Deb stated that the provider manual details this process and that she will develop a work flow chart on the waiver application process for distribution at the April Executive Committee. Deb stated that a member can have additional services provided either by utilizing state plan or by paying for it themselves with the agreement of the member.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Liz stated that CAHPS is intended to measure consumer experience within the healthcare system, not consumer satisfaction. She stated that the Department requires the MCOs to perform areas that are specific to the healthcare delivery systems. She indicated that there are surveys for both adults and children that look at the member's experience with their insurance provider and provider network. The surveys contain questions regarding four main areas: Getting needed care; Getting care quickly; How well doctors communicate; and Health plan information and customer service. She stated that the MCOs use independent contractors to conduct these surveys and the MCOs are required to report the CAHPS data to the Department. She stated that in the 2017 metrics, all MCOs scored above the national median in adult surveys although one area of the children surveys was below the national median; 'The customer services always or are usually helpful'. Liz indicated that CAHPS data is in the quarterly reports. She indicated that the department conducts a variety of surveys and is currently reviewing existing surveys to ensure collection of meaningful data. She mentioned that CAHPS and Healthcare Effectiveness Data and Information Set (HEDIS) data are a part of National Committee for Quality Assurance (NCQA) ratings.

Medicaid Director's Update

Process Improvement Workgroup:
Mike stated that the workgroup was to meet on March 23, 2018, and that feedback is being reviewed so that sub-workgroups may be formed to address the feedback before moving forward.

Amerigroup Transition:
Mike confirmed there are no known issues with the transition of the 10,000 members to Amerigroup. He stated that the IME and the MCOs continue to work closely to ensure a smooth transition and transfer of members and member data. Effective May 1, 2018, Amerigroup will begin accepting new members.

New MCO RFP Process:
He stated that two organizations submitted responses and they were received on March 6, 2018. He stated that the department is currently evaluating the RFPs that were received with the intent to select the new MCO by the end of April 2018 with contract negotiations and a readiness timeline for a July 1, 2019 start.

Mike stated that in adding new MCO(s), an algorithm-based methodology will be developed for distributing membership equitably across the MCOs but that all members will have choice.

Open Discussion

David stated that a provider had informed him that there were a number of people being audited by AmeriHealth Caritas in an effort to collect funds that had been lost. Cindy stated that providers receive

letters stating that the MCO is auditing claims, or there are special projects that they are reviewing. Mike stated that he would review the information and documentation.

David asked if the MCO contracts provide for a definition of “medical necessity” as he did not see it defined clearly in the Amerigroup contract; asking within the context of denial of a service deemed to not be medically necessary. Mike offered to address this by stating that the complex nature of the Medicaid member population groups and their various needs make defining the term medical necessity difficult however, there are however clinical guidelines that define medical necessity. Mike stated that medical necessity is not determined by a case manager it is determined by clinicians in the specified area. Liz stated that there is an outline that is consistent with the federal program for Medicaid and Medicare. In the glossary there is a definition of medical necessity and the contractor uses their Utilization Management guidelines to determine medical necessity.

David inquired about House File (HF) 2292 and HF 2462. Mike offered to sit down privately with David about his questions regarding these bills but that a legislative update will be provided at the next Executive Committee meeting in April.

Flora Schmidt asked that the Department provide an update on the Department’s Health Home reviews. Mike stated that the Health Home contractor will be providing an update that includes a project timeline within the next two weeks and once completed, he would like to commence department and stakeholder/provider engagement to develop a robust and comprehensive communications plan on Health Homes.

Agenda Item:

- Legislative update by Mike Randol for the April Executive Committee meeting.

Adjourn
4:19 P.M.